

APPENDIX A to He-E 605
STANDARD DISCLOSURE SUMMARY

For an electronic form contact pknight@dhhs.state.nh.us at the NH Division of Elderly and Adult Services.

FACILITY: _____

Base Rate: \$ _____ ☐ Monthly ☐ Weekly

☐ **Deposit/Advance Payment** \$ _____

☐ **Refundable** ☐ **Non-refundable** ☐ **Partially Refundable**

SERVICES INCLUDED IN THE BASE RATE:

Meals: Daily # of Meals: _____ Check (✓) all that apply:

☐ Breakfast ☐ Lunch ☐ Special Diets ☐ Dinner ☐ Snacks

Housekeeping:

☐ Times per Week: _____ Hours per Visit: _____ ☐ Other: _____

Laundry Services:

☐ Personal _____ Loads/week (if limited) ☐ Linens

Personal Assistance:

☐ Toileting ☐ Dressing ☐ Grooming ☐ Bathing

☐ Eating ☐ Mobility ☐ Medication Administration

☐ Monitoring or supervision of medications

☐ Monitoring or supervision of residents who wander (describe): _____

☐ Other: _____

Personal Living Unit Amenities: Check (✓) all that apply. If amenities are located in common areas and shared with other residents put "S" in box.

<input type="checkbox"/> Emergency Call System	<input type="checkbox"/> Fully Furnished Unit	<input type="checkbox"/> Stove/Oven
<input type="checkbox"/> Toilet and Sink	<input type="checkbox"/> Window Treatment	<input type="checkbox"/> Microwave Oven
<input type="checkbox"/> Shower/Bathtub	<input type="checkbox"/> Carpeting	<input type="checkbox"/> Stove-top Burner
<input type="checkbox"/> Basic Cable TV Service	<input type="checkbox"/> Cable TV hookup	<input type="checkbox"/> Telephone Hookup
<input type="checkbox"/> Refrigerator/Freezer	<input type="checkbox"/> Mini-refrigerator	<input type="checkbox"/> Local Phone Service
	<input type="checkbox"/> Lockable Door	<input type="checkbox"/> Pets Allowed
	<input type="checkbox"/> Gas/Electric/Water	<input type="checkbox"/> Off-site Storage

☐ Other: _____

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Staff Coverage:(Check (✓) all that apply)

- | | | | |
|---------------------------------------------------------------------|---------------------|----------------------|--|
| <input type="checkbox"/> On-Duty Staff on Premises 24 hours per day | | | |
| <input type="checkbox"/> Licensed Nurse | Onsite Hours: _____ | On-Call Hours: _____ | |
| <input type="checkbox"/> Personal Care Attendant | Onsite Hours: _____ | On-Call Hours: _____ | |
| <input type="checkbox"/> Licensed Nursing Asst.-LNA | Onsite Hours: _____ | On-Call Hours: _____ | |
| <input type="checkbox"/> Building Maintenance Staff | Onsite Hours: _____ | On-Call Hours: _____ | |
| <input type="checkbox"/> Other: _____ | | | |

Transportation:

- | | |
|--------------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Daily | <input type="checkbox"/> _____ Times per week |
| <input type="checkbox"/> Scheduled Route Only | <input type="checkbox"/> Unscheduled/On Call |
| <input type="checkbox"/> Car | <input type="checkbox"/> Van/Mini Bus with lift |
| <input type="checkbox"/> Available Destinations (if limited): _____ | |
| <input type="checkbox"/> Geographic/mileage limitations (specify): _____ | |

Recreation and Leisure (Indicate Activity and Schedule):

Other Services Included in Base Rate:

**Services not included in Base Rate, but available for an extra charge.
(Please include cost and unit of service. You may attach a separate sheet
if additional space is needed.)**

Regulatory Oversight (Please check (✓) if applicable):

- | |
|------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Licensed/Certified Health Facility (RSA 151) Type: _____ |
| <input type="checkbox"/> Continuing Care Community Regulated by Dept. of Insurance (RSA 420-D) |
| <input type="checkbox"/> Other: _____ |

**This form is a summary. Please see “Residential Services Agreement” for
a full description of the most current costs, services, rules, and policies.**

Completed by: _____ Date: _____